

FILED JAN 15 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

805

BIRTH NO.		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 20			
1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield					
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital				d. STREET ADDRESS (If rural, give location) 1524 E Atlantic					
3. NAME OF DECEASED (Type or Print)		a. (First) Caroline		b. (Middle) Sue		c. (Last) Detherow			
4. DATE OF DEATH		(Month) (Day) (Year)		January 8 1951					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH Feb 21, 1949			
9. AGE (In years last birthday)		10. MONTHS 10		11. DAYS 17		12. IF UNDER 1 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Springfield, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Miodo Leon Detherow		13b. MOTHER'S MAIDEN NAME Verna Lucille Swanson		14. NAME OF HUSBAND OR WIFE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miodo Leon Detherow, Springfield, Mo.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Natural Death of unknown cause ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) premature birth with congenital circulatory defect DUE TO (c) UNATTENDED BY A PHYSICIAN II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH 7-246				19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that death occurred at 5:50 P.m., from the causes and on the date stated above.									
23a. SIGNATURE W. E. Handley MD		23b. ADDRESS City Hall Springfield Mo		23c. DATE SIGNED 1/10-51					
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan 10, 1951		24c. NAME OF CEMETERY OR CREMATORY Eastlawn Cemetery		24d. LOCATION (City, town, or county) (State) Springfield, Missouri			
DATE REC'D BY LOCAL REG. 1-10-51		REGISTRAR'S SIGNATURE W. E. Handley MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rev Alma Schmeiser, Springfield, Mo.					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. H.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed Bernard F. Wright

Licensed Embalmer No. 4293

P. O. Address. Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.